# Making Things HAPPEN

## Decentralized Planning for RCH in Uttar Pradesh, India

July 20, 1999

The POLICY Project
The Futures Group International

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*in collaboration with:*

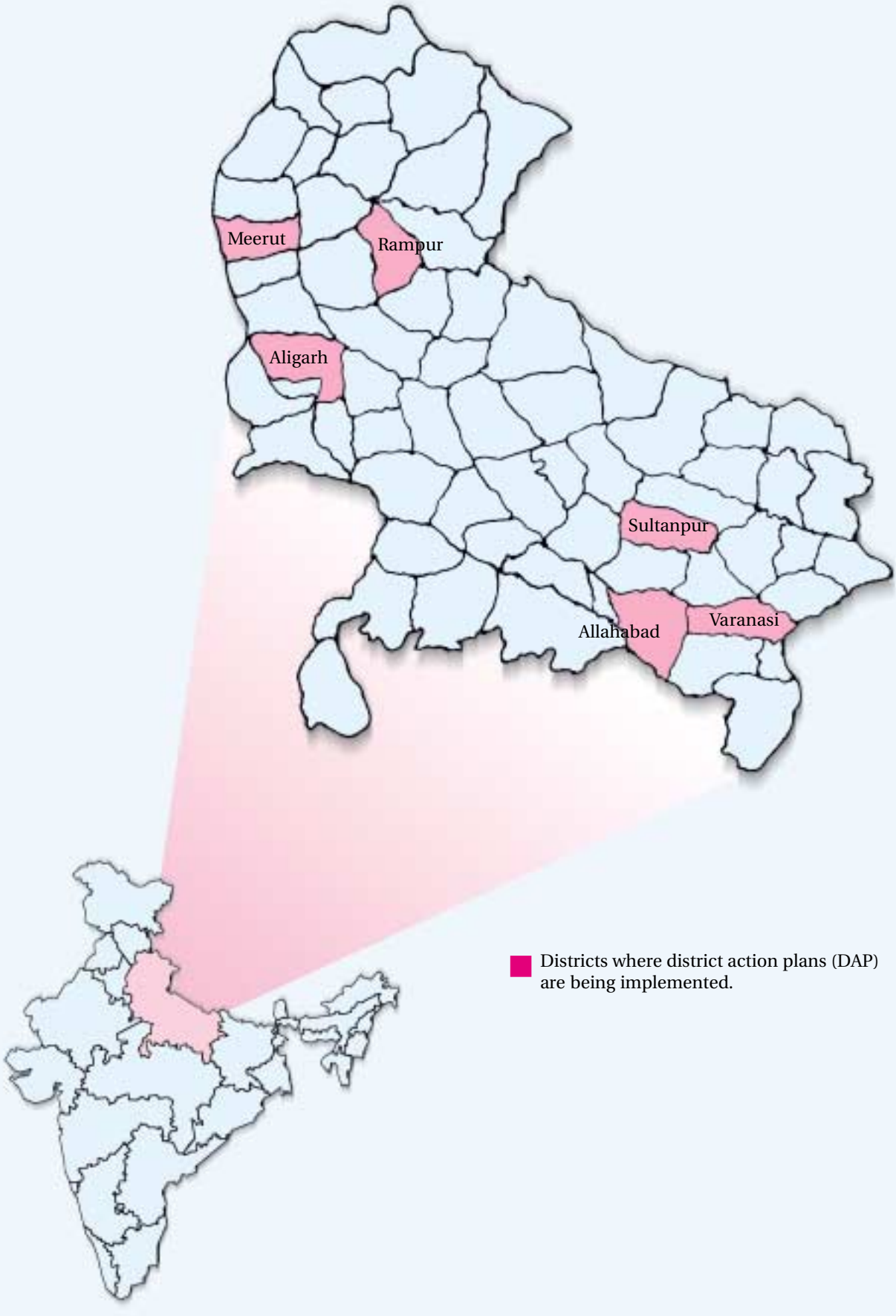
Research Triangle Institute (RTI)

The Centre for Development and Population Activities (CEDPA)

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. It is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and the Centre for Development and Population Activities (CEDPA). The views expressed in this report do not necessarily reflect those of USAID.

# Contents

# Uttar Pradesh




Districts where district action plans (DAP) are being implemented.

# Foreword

As we approach the next century several things are now certain about world population growth. We know that population size will continue to grow. Today it is increasing by more than 80 million per year and 98% of this growth is in the developing world. Thus the eventual size of the world's population will depend in large part, upon how many children, the young couples of today decide to have in their lifetime. It will also depend on changes in life expectancy in developing countries.

We began this century with a population of 1.6 billion. By 1960 that global total had become 3 billion and by 1987, 5 billion. The sixth billion will come next year. Currently we are adding a billion people every 12 to 13 years.

The population of U.P. was 48.6 million at the turn of the century & is 165 million today. It is projected to grow upto 300 million in 2031. Today we are adding an additional 3.8 million people annually to our already over crowded state.

The Govt. of India realized the need for population control early and thus we had the first family planning programme in the world in 1951. But inspite of some notable achievements, it has not been able to reduce the birth rate in U.P. to a level commensurate with the social and economic objectives of the State. The average number of children born to a woman in U.P. as per the National Family Health Survey of 1992 still remains about 5. Thus it is apparent that special efforts have to be made to make a major impact on this problem. It is in this context that the SIFPSA Project is of crucial importance.

Over the last few years SIFPSA has been able to develop a number of innovative models for expanding and improving quality of health & family planning services. Use of non-government organizations (NGOs), indigenous systems of medicine and homeopathy (ISM&H) practitioners, working through dairy cooperatives are some of the interventions, which have proved successful and are being replicated.

However, perhaps the most for reaching innovation in terms of methodology, scope and content have been the District Action Plans (DAPs). To my mind they are important, not only because they are the first attempt, on a large scale, to identify local needs in a participative manner but also because they attempt to see how best we can functionally optimize the health system. The DAPs provide a model to improve the effectiveness and efficiency of the vast health and family welfare infrastructure by bringing about a synergy between the private and public sector and by introducing an RCH management system at the district level. This has also made the family welfare programme more

responsive to the needs of the people and accountable to the community.

The timing of this initiative is also welcome as it comes at a time when the State of U.P. has taken rapid strides in effectively decentralizing programmes across various development sectors to the district and village levels through Panchayati Raj institutions. In this context I would also like to emphasize that we should make full use of the decentralization policy of the Government wherein we have empowered the panchayats to perform in key sectors of development. Perhaps in Uttar Pradesh with its large rural component, this might be the most effective strategy to implement this policy.

I am happy to note that The POLICY Project has documented the first year of the experiences of implementation of the DAPs in 6 districts of U.P. covering a population of more that 15 million. This document will, I am sure, be invaluable to policy makers and programme managers working in the area of RCH and will, along with other measures adopted by the Govt. of U.P., go a long way in reaching the objective of providing decentralized people based health care.

19th July, 1999

(Yogendra Narain)
Chief Secretary, U.P.

# Preface

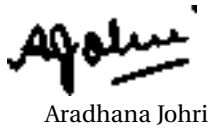
In Uttar Pradesh, the State Innovations in Family Planning Agency (SIFPSA) is responsible for managing and implementing the USAID-funded Innovations in Family Planning Services (IFPS) project. The strategic objective of this project is to *significantly reduce the total fertility rate and improve women's reproductive health* in the state. To achieve this objective, SIFPSA is charged with the comprehensive improvement and expansion of reproductive health and family planning services in Uttar Pradesh.

The three intermediate results of the IFPS project are to (1) *improve the quality of family planning and other reproductive health services through a client-centred focus*; (2) *increase access by strengthening public and private sector service delivery systems*; and (3) *increase demand through broadening support among leadership groups and increasing public knowledge of the health and welfare benefits of family planning*. SIFPSA and USAID have adopted a phased approach for the project, implementing innovative interventions in selected districts, evaluating the interventions, and expanding successful interventions to other districts in Uttar Pradesh.

Decentralized planning is one of SIFPSA's innovative interventions. SIFPSA funded and facilitated the development of district action plans in six districts: Aligarh, Allahabad, Meerut, Rampur, Sultanpur, and Varanasi. The rationale for district planning is to encourage bottom-up planning, taking into account local needs and resources. District planning ensures the devolution of administrative and financial authority to the districts, with continued technical assistance from SIFPSA to streamline service delivery systems. The district planning exercise also included the creation of District Innovations in Family Planning Services Project Agencies (DIFPSAs) and Project Management Units (PMUs) to provide operational linkages between SIFPSA, the districts, and the public and private sectors.

This document is the report of an external assessment conducted by the POLICY Project. It discusses the experiences with the planning process, implementation, and outcomes. The DAP interventions cover a population of 15 million. They emphasize quality of service and the provision of integrated reproductive health services. This document assesses the accomplishments and lessons learned in the first year of DAP implementation.

I would like to commend the POLICY Project team, comprising of Dr. G. Narayana, Mr. J.S. Deepak, Dr. D.K. Mangal, Dr. K.M. Sathyanarayana, Mr. Ashok Kumar Singh and Ms. Emily Pierce, for their meticulous documentation of the processes and outcomes of the district planning exercise in Uttar Pradesh. This document will prove useful to all involved in DAP implementation as it moves into the second year and to others working toward similar objectives in the Family Welfare sector in Uttar Pradesh and all of India.



Aradhana Johri
Executive Director
SIFPSA

# Abbreviations

| | |
|---|---|
| ANM | Auxiliary Nurse Midwife |
| BDO | Block Development Officer |
| CBD | Community-based Distribution |
| CBFPT | Clinic-based Family Planning Training |
| CDO | Chief Development Officer |
| CHC | Community Health Centre |
| CMO | Chief Medical Officer |
| DAP | District Action Plan |
| DIFPSA | District Innovations in Family Planning Services Project Agency |
| DM | District Magistrate |
| IEC | Information, Education, and Communication |
| IFA | Iron Folic Acid |
| IFPS | Innovations in Family Planning Services |
| ISMP | Indigenous Systems of Medicine Practitioner |
| IUCD | Intra-uterine Contraceptive Device |
| MCH | Maternal and Child Health |
| MIS | Management Information System |
| NGO | Nongovernmental Organization |
| PBDS | Performance-based Distribution System |
| PCDF | Pradeshik Cooperative Dairy Federation |
| PHC | Primary Health Centre |
| PMU | Project Management Unit |
| PPC | Postpartum Centre |
| PVO | Private Voluntary Organization |
| RCH | Reproductive and Child Health |
| RFWTC | Regional Family Welfare Training Centre |
| SIFPSA | State Innovations in Family Planning Services Project Agency |
| SIRD | State Institute for Rural Development |
| TBA | Traditional Birth Attendant |
| TOT | Training-of-trainers |
| TT | Tetanus Toxoid |
| USAID | United States Agency for International Development |

# The Planning Process

## Decentralized Planning

In India, the planning process has remained highly centralized, despite several attempts to introduce and institutionalize decentralized planning. Wide variations in the needs, problems, and priorities at the local level, particularly in states as large and diverse as Uttar Pradesh, make it very difficult for one central organization to plan for any sector according to local needs and preferences. Policy makers and planners recognize the major benefits of decentralization, which include higher quality programme implementation, increased flexibility, and better ability to respond to changing conditions.

During the Third Plan, the panchayats were given the authority and responsibility to prepare block plans for the first time, but because of glaring gaps in the planning machinery, little was achieved. As a result, during the Fourth Plan, the government of India launched an initiative to strengthen the state planning machinery. During the Sixth Plan, the initiative was extended to the districts on a cost-sharing basis.

At the national level, successive governments have convened several committees to develop specific guidelines for decentralized or multilevel planning. These committees have emphasized the planning process, and the guidelines developed include: formulating plan objectives, compiling data, developing a primary strategy, analysing existing programmes based on the strategy outlined, assessing resources, and establishing links between the planning levels. However, the attempts to implement the guidelines did not go beyond the establishment of planning boards at the state and district levels. In practice, decentralized planning remained an administrative exercise.

The failure of decentralized planning is primarily due to the absence of stakeholder participation in the planning process and the lack of reliable and adequate data for planning purposes. In addition, many decentralized plans have not outlined specific parameters for the transfer of authority.

In Uttar Pradesh, the State Innovations in Family Planning Services Project Agency (SIFPSA) facilitated the preparation of district action plans (DAPs) in six districts for the family welfare sector. This pioneering effort was the first of its kind in Uttar Pradesh, perhaps in all of India. The preparation of the plans was a participatory process, using reliable, district-level data and a simple, specific, and practical approach.

## Formulation of District Action Plans

The PERFORM Survey conducted in 1995 in 28 districts of Uttar Pradesh provided reliable data on fertility and contraceptive behaviour and on use of private and public sector services. Based on the rich information available for each of the 28 districts, POLICY prepared a booklet and an audiovisual highlighting current status on various key indicators and disseminated copies to district health and development officers, industrialists, social workers, representatives of private voluntary organizations (PVOs), and private practitioners. Later, dissemination workshops were conducted at the block level for supervisors and grassroot workers. During these dissemination workshops, various groups voiced the need for district-specific strategies based on local needs and resources available. Participants cited the centralized, uniform approach and the isolation of programme efforts as the main reasons for poor performance. Encouraged by the positive response to the idea of district-level planning, SIFPSA decided to develop the district action plans.

The primary issues to resolve were the methodology for developing the district action plans and the extent to which the implementation of the plans should be decentralized. A participatory approach evolved from collective thinking and effort. SIFPSA identified six districts (all first-phase priority districts of the USAID-funded Innovations in Family Planning Services (IFPS Project) for preparation of district action plans.

As a first step, SIFPSA conducted a two-day workshop for the Chief Medical Officers (CMOs) and Deputy CMOs of the selected districts to finalize the planning methodology and set objectives for a three-year period. The teams used the PERFORM Survey data and SPECTRUM software to set these objectives, and the medical officers then modified the objectives based on district

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experience. During these workshops, the participants also identified information needed to prepare comprehensive plans. The district officers then collected the information about available programme resources, including infrastructure facilities, transportation, personnel, and information, education, and communication (IEC) activities. They also identified *dais* (traditional birth attendants [TBAs]) in each village, indigenous system of medicine practitioners (ISMPs), and NGOs active in the districts as additional resources to be integrated. Each district team also asked workers, supervisors, and medical officers for suggestions on district-specific strategies to improve programme performance. The teams compiled this information and conducted a workshop in each district for all stakeholders to discuss the strategies. The district action plan documents are based on the consensus of these workshops. The Governing Body of SIFPSA approved all six district action plans in the third week of March, 1998.

*The emphasis on an integrated approach is to identify and use all resources available in the district in both public and private sectors to achieve the plan objectives.*

## Developing Systems for DAP Implementation

The district action plan implementation systems are based on two major principles: (1) decentralization, and (2) integration. Decentralization of power and functions is necessary to provide flexibility and allow decision making based on local needs and conditions. The emphasis on an integrated approach is to identify and use all resources available in the district in both public and private sectors to achieve the plan objectives. These two principles guided the development of systems and processes at district level for plan implementation.

In each district, the District Innovations in Family Planning Services Agency (DIFPSA) was registered with the Registrar of Societies. The District Magistrate (DM), who coordinates the activities of all departments in the district, was elected chairperson. Other members of the agency included the Chief Development Officer (CDO), the CMO, the Deputy CMO of Family Welfare, NGO representatives, industrialists, and prominent citizens of the district. DIFPSA members met once a month to review implementation progress and Reproductive and Child Health (RCH) performance and to discuss problems. The District

Magistrates not only conducted the meetings but also actively participated in implementation. They supervised the projects, provided additional resources, monitored quality, and mobilized public support for the programmes.

To assist DIFPSA at the district level, SIFPSA established Project Management Units (PMUs) comprising one project manager, one assistant project manager, one accountant, one management information system (MIS) specialist, and support staff. Within two months, SIFPSA rented facilities for the PMUs in key locations in each district and purchased office equipment and vehicles. New staff members traveled to Lucknow for a one-week training at SIFPSA. In consultation with DIFPSA, PMU staff designed and implemented administrative, financial, and information systems. SIFPSA transferred the total amount of estimated expenditures for the first year of plan implementation to DIFPSA accounts, and the systems were in place by the end of July 1998.

PMUs monitor various projects and plan components, send weekly and monthly reports to SIFPSA, and share these reports with DIFPSA. All reports are on standardized forms specifically designed for the DAPs and maintained in the MIS at the district level. SIFPSA holds quarterly meetings of PMUs to discuss problems, provide technical support, and assist in the decision making process. PMUs are encouraged to present their achievements and the issues they encounter.

During the year, PMUs have emerged as the hub of all activities. The PMU serves as a problem solving agency, a source for dissemination of information, the link between public and private sectors, and, above all, the field representative of SIFPSA.

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## Assessment of DAP Implementation

The district action plans include five clearly identified and articulated strategies: (1) creating a conducive environment; (2) generating demand through IEC; (3) improving quality of services; (4) improving access to integrated services; and (5) involving the nongovernmental sector. The planning teams identified specific activities for each strategy and prepared a time-frame for the activities.

Upon the request of SIFPSA, the POLICY Project conducted an assessment of the first year of DAP implementation to record the experiences of implementation, review progress made, and evaluate the achievement of stated plan objectives. The assessment teams interviewed representatives of private sector projects, health officers at various levels, PMU staff, and other stakeholders involved in plan implementation. They reviewed records of PMU offices, minutes of meetings of DIFPSA, memos, and various weekly, monthly, and quarterly reports. They also held discussions with representatives of SIFPSA and cooperating agencies (CEDPA, INTRAH-PRIME, AVSC International, Johns Hopkins University-Population Communication Services, and Contraceptive Marketing Strategy) who were also involved in providing technical assistance for implementation of various components of the DAPs. In addition, the team analyzed family planning performance for the year 1998-99 and compared it with performance for 1997-98. This report provides a summary of the assessment, including activities implemented, progress achieved, and the issues involved.

# Creating a Conducive Environment

Social mobilization by community leaders is essential to the success of programmes that emphasize behavioural change. The family welfare programme in Uttar Pradesh does not have the continuous support of community leaders. To create a conducive environment for the programme, the support of religious leaders and village heads *(pradhans)* is crucial. The district action plans call for a series of meetings/ training programmes for these leaders to garner their support and involve them in family welfare programme implementation.

## Religious Leaders

In each district, the PMU office prepared a list of religious leaders belonging to different religious communities. In particular, Allahabad and Varanasi districts have many prominent religious leaders. In other districts, prominent religious leaders as well as eminent scholars were invited to the meetings. In preparation, staff reviewed literature on religion and family planning and compiled reading materials for distribution at the meetings.

In all districts, informal meetings were held with a small group of religious leaders to share the literature and elicit opinions on how to conduct the broader meetings. These initial meetings helped to avoid offending the religious sentiments of any particular community. However, many prominent religious leaders were initially reluctant to participate in the meetings. The DMs and CDOs put a great deal of effort to encourage them to attend, and, overall, 837 leaders participated in a meeting (Table 1).

Those who did attend the meetings endorsed the view that religion, in any form, does not conflict with the use of modern contraceptive methods. The visible and positive outcome of these meetings is that, the leaders

**Table 1: Meetings with Religious Leaders**

| | *Planned Performance* | | *Actual Performance* | |
|---|---|---|---|---|
| **District** | **Number of Meetings** | **Number of Participants** | **Number of Meetings** | **Number of Participants** |
| Allahabad | 1 | 60 | 2 | 148 |
| Aligarh | 4 | 120 | 1 | 27 |
| Meerut | 1 | 20 | 1 | 28 |
| Rampur | 4 | 200 | none | --- |
| Sultanpur | 12 | 600 | 6 | 180 |
| Varanasi | 16 | 480 | 16 | 457 |
| **Total** | **38** | **1480** | **26** | **837** |

of different religions unanimously voiced their support to family planning. Some religious leaders suggested that recordings of statements by religious leaders be prepared, to disseminate religious views on family planning. A few religious leaders actively participated in immunization camps, and a few sponsored RCH camps. Continuous effort is required to encourage the broader participation of opinion leaders and prominent individuals from different religious communities.

## Village *Pradhans*

The 73rd Amendment to the Constitution of India mandated the election of *panchayat* bodies in all villages, and the envisaged role of *pradhans* in development activities, particularly public health and family welfare, is significant. In fulfillment of the constitutional requirement, the Government of Uttar Pradesh recently shifted authority for female health workers and the first line supervisors from the health department to the *panchayati raj*. In the past, *pradhans* maintained contacts with the development departments and focused on activities that provided visible returns, such as building construction, roads, transport facilities, and water resources. Contacts between *pradhans* and the health department were rare; many *pradhans* were not even aware of the services available in health institutions. Given these constraints, their contribution to

*The visible and positive outcome of these meetings is that, the leaders of different religions unanimously voiced their support to family planning.*

# Commendable Task by Woman *Pradhan* in Gauriganj

Encouraged by the response of *pradhans* to training programmes, the District Magistrate of Sultanpur decided to link development programmes with family welfare. He challenged *pradhans* to motivate 25 new users of modern contraceptive methods in a fiscal year, promising to match their efforts in family planning with other development initiatives. Even though the scheme was announced only three months before the end of the fiscal year, 21 *pradhans* successfully responded to the DM's challenge in 1998-99.

After attending the *pradhan* training at block level, Sitara Devi, a female *pradhan* from a village in Gauriganj block of Sultanpur, started to advocate use of family planning methods in her village. She motivated 23 sterilization clients, without knowing about the new scheme announced by the District Magistrate. She provided transportation for clients and, at times, even accompanied them to the PHC. She also provided food to family members of acceptors for three days until the women were ready to take care of their household chores. In the last month of the fiscal year, she became aware of the DM's challenge. She was eager to avail the benefits and persuaded two more clients. She took them to PHC on March 31, 1999, but the medical officer informed her that sterilization services are provided only on camp day. Disappointed, Sitara Devi and the clients returned to village. She said, "I will definitely strive to reach a performance level of minimum 25 clients next year. I just lost one year, but it does not really matter."

the family welfare programme was minimal.

In the DAP districts, there are 6,657 elected *pradhans*, and one-third of them (2,219) are female. Training such a large number in a short period is a major task that can only be accomplished by utilizing all existing resources and identifying new resources. SIFPSA identified the State Institute for Rural Development (SIRD), an apex institution at the state level, to train development officers at various levels, and created a special unit within this institution to train *pradhans* on reproductive health programmes and services. CEDPA and SIFPSA provided technical assistance to SIRD in developing material for the training-of-trainers (TOT) and *pradhan* training programmes. SIFPSA also designed and printed posters and calendars with RCH messages, to be distributed to *pradhans* at the training sessions.

Staff visited the districts and, with the help of district officers, selected the lead trainers. The number of lead trainers selected, depended on the size of the district and number of *pradhans* to be trained. SIRD conducted three-day TOT programmes for the lead trainers in Lucknow. During the programmes, the lead trainers made detailed plans for the *pradhans* training. Each PMU collected the addresses of all *pradhans* in each block from the Chief Development Officer (CDO). DIFPSA decided that both CDOs and CMOs should write letters to *pradhans* inviting them to attend the training programmes. Some Block Development Officers (BDOs) also sent letters to *pradhans*. In addition, auxiliary nurse midwives (ANMs) personally contacted *pradhans* in their subcentre area and encouraged them to participate in the training. Project Managers of DAPs invited NGO project coordinators in the block to participate in training as observers.

As a result of these efforts, nearly two-thirds of *pradhans* in these six districts received training on reproductive and child health services for the first time in the history of the family welfare programme in Uttar Pradesh. They learned about the important role they can play in making a wide range of health services available to villagers, particularly women and children. Of the total *pradhans* trained in the six districts, 955 (22 percent) were female. In areas where cultural practices prevent female *pradhans* from attending the training along with males, their husbands, popularly known as *pradhan patis*, attended the training. The response rate varied from district to district. Almost all *pradhans* or *pradhan patis* in Meerut and Allahabad were trained, and nearly half attended training in Aligarh, Sultanpur, and Varanasi. However, in Rampur, the response from *pradhans* was poor (Table 2).

*As a result of the efforts put in by SIFPSA in conducting training programme for pradhans, nearly two-thirds of pradhans in DAP districts received training on reproductive and child health services for the first time in the history of the family welfare programme in Uttar Pradesh.*

# Setting a New Trend
## *Pradhan Pati* Rejuvenates Badagaon PHC

Hyder Ali, known to local people as *pradhan* of a village in the Badagaon PHC area in Varanasi, is actually a *pradhan pati*. His wife contested and won the elections, but she never actively participated in public affairs. Hyder Ali attended the training programme on behalf of his wife. He said that curiosity to know what the training was all about prompted him to travel to the block headquarters. After the training, he was convinced of the benefits of the family welfare programme. Having established contacts with the PHC medical officers, he now regularly takes women and children of his village in need of health services to the Badagaon PHC. He also motivated several women of his village to undergo a sterilization operation. Recognizing Ali's contribution to the health programmes, PHC medical officers accord priority to clients referred by him, in turn enhancing his reputation among villagers as a person who can get things done.

**Table 2: *Pradhan* Training**

| | *Planned Performance* | | *Actual Performance* | | | |
|---|---|---|---|---|---|---|
| **District** | **Number of *Pradhans*** | **Training Programmes** | ***Pradhans* Trained** | **Percentage Trained** | **Trained *Pradhans* Reoriented** | **Percentage Reoriented** |
| Allahabad | 1500 | 54 | 1378 | 91.9 | 498 | 36.1 |
| Aligarh | 1067 | 32 | 489 | 45.8 | 208 | 42.5 |
| Meerut | 620 | NA | 594 | 95.8 | 193 | 32.5 |
| Rampur | 914 | 19 | 261 | 28.6 | 93 | 35.6 |
| Sultanpur | 1675 | 42 | 823 | 49.1 | 453 | 55.0 |
| Varanasi | 921 | 27 | 574 | 62.3 | 150 | 26.1 |
| **Total** | **6657** | **174** | **4119** | **61.9** | **1595** | **38.7** |

Reorientation training for trained *pradhans* was launched in January 1999. The training venues were shifted from block headquarters to community health centres/ primary health centres (CHCs/ PHCs) to familiarize *pradhans* with CHC/PHC staff and to make them aware of the types of services available at the CHC/ PHC and subcentre levels. Training programmes were conducted on RCH camp day. Attendance at the reorientation training sessions was lower than attendance at the initial training sessions at block headquarters, and included predominately those *pradhans* who were already interested in the improvement of community health services. Low attendance was also due to lack of proper public transport facilities to reach CHC/PHC. However, considering that this was the first effort to establish interaction between *pradhans* and health institutions, the participation of nearly 40 per cent of trained *pradhans* in reorientation training is encouraging, and their contributions to the programme have been significant.

# Generating Demand

## IEC Campaigns

To generate demand for reproductive health services, SIFPSA launched a major IEC campaign in Uttar Pradesh, also covering the DAP districts. The campaign, *Aao Batien Karein* (Come Let's Talk), is illustrated by the Tota and Mynah birds. The campaign was designed to foster communication between couples aged 17-25 years, providers and clients, and family members. The campaign has been used to inform people, raise awareness, and allay the myriad of myths and misinformation about family planning.

## Interpersonal Communication

SIFPSA conducted interpersonal communication skills training in all six districts through a series of workshops of one-day duration using lectures, games, exercises, and a 25-minute training video. The main objective of the training was to orient participants to the campaign theme, *Aao Batien Karein,* impart client counselling skills, and familiarize workers with the IEC campaign material. All the workers in public sector and SIFPSA-funded private sector projects have been trained.

The training was conducted in an entertaining and interactive manner; the format of *melas* (village fairs) was used in blocks with more than 100 workers. At the end of the training, participants received a bag containing IEC materials such as a flip book, a poster, a sticker, a badge, a wall chart, and a calendar displaying family planning methods. The PMUs in each district monitored the training programmes. Health workers feel that the IEC material has been very useful for conducting group meetings in villages and clinics and interacting with women. In addition, the badge has given them a sense of identity. The interpersonal communication training has improved the skills of service providers in both the

public and private sector, and the IEC materials have facilitated interaction with community members and clients.

## Folk Media

Folk performances are an important form of entertainment media in rural areas. *Nautanki* (folk theater), *Qawali* (singers of devotional songs), *Allah/Birha* (traditional ballad singers), and puppetry are extremely popular in rural Uttar Pradesh. SIFPSA contracted a training agency to develop scripts containing messages about family planning for each folk media form. They obtained a list of troupes from the Department of Information and the Song and Drama Division of All India Radio, selected troupes based on experience and popularity, and trained the troupes to perform the script specifically prepared for them.

With the help of the PMU in each district, SIFPSA identified villages with a population of 2,000 or more in all blocks covered by SIFPSA-funded PVO projects and prepared a detailed route map and schedule for the folk performances. The PVO working in the block coordinated the activities, monitored performances, and disbursed funds to the troupes. In addition, PMU staff members attended the shows and sent feedback to SIFPSA on each performance.

The response of community to the folk performances in the DAP districts has been overwhelming. In case of electricity failure, villagers provided tractor batteries to ensure uninterrupted performances. Pleased with the artistic skills of performers, some villagers voluntarily contributed money to the troupe. Invariably, villagers extended hospitality, such as providing food and snacks. After folk performances in villages with community-based distribution (CBD) workers, several men and women wanted to know more about family planning methods, and some selected a method for use. The PMUs have received several requests to repeat the programme, and villages not covered have requested performances. Overall, the dissemination of family planning information through folk theatre has been a major success in rural areas of DAP districts and has the potential to generate demand for family planning services

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# Improving Quality of Services

SIFPSA has used different approaches to improve the quality of services. In addition to enhancing technical skills, changing the attitudes of health service providers is an important aspect of quality improvement. With this objective in mind, SIFPSA designed a series of training programmes for female health workers, medical officers, health institution staff, *dais*, and ISMPs. Another barrier to quality of service is the condition of facilities; several service delivery points do not meet minimum standards. SIFPSA has been upgrading facilities to meet standards and improve quality of services.

## Clinic-based Family Planning Training

Studies conducted on practices followed by female health workers showed that the quality standards maintained were low, particularly for intra-uterine contraceptive device (IUCD) insertion procedures. Often female health workers did not screen or counsel clients before providing IUCDs. In addition, many workers did not use proper techniques for insertion, resulting in high expulsion rates and raising concerns about the acceptor's health. Given this scenario, the DAPs identified the need to provide clinic-based family planning training (CBFPT) to female health workers. Planners also recognized that clinic-based training must be a continuous process, not merely a one-time effort.

The first step was to identify training sites. The criteria used for selecting the training site were the presence of lady medical officer, availability of enough clients for trainees to practice inserting IUCDs, and facilities for classroom training. In addition to the lady medical officer at each training site, SIFPSA identified either a public health nurse or a staff nurse to serve as a trainer at each site. All the trainers travelled

to Lucknow for a two-week training programme on clinical practices and TOT.

INTRAH-PRIME and SIFPSA developed the CBFPT manuals. Four female health workers attend each training programme. The one-week programme has several modules, and at the end of each module, the trainees are quizzed to ensure that they understand the material. They first practice IUCD insertion on a ZOE pelvic model and then on at least two clients. After completing the training, each female health worker receives a certificate and an IUCD insertion kit. To maintain quality standards at the subcentre level, SIFPSA has streamlined the supply of consumables to these sites.

SIFPSA identified 33 training sites and trained 66 lead trainers. The training at two sites was cancelled because of the lack of clients or the transfer of the lady medical officer. Of the 2,543 female workers in all six districts, 792 were trained in the first five months (Table 3). The remaining workers are expected to be trained in the second year of DAP implementation.

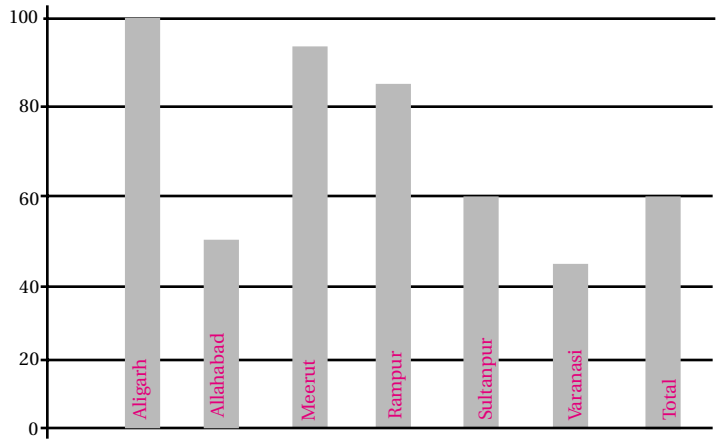
In addition, Regional Family Welfare Training Centre (RFWTC) staff were trained to observe the programmes and conduct follow up visits to monitor the quality standards maintained by the female health workers in the field. RFWTC observers visit the female health workers one month after training. They review the quizzes completed by the female health workers during training, observe insertion of IUCDs, check technical procedures, review counselling skills, and score the performance of the workers using a standard form specifically designed for the evaluation. If the female health worker receives a score of 80 percent or above, she is considered to be performing to standards. RFWTC observers send reports on the monitoring and the number of workers requiring follow up to DIFPSA, SIFPSA, and INTRAH-PRIME.

*60 percent of trained workers are performing to standards, indicating a significant improvement in the quality of IUCD insertion and removal services. Satisfaction levels will increase, and, as a result, the acceptance of IUCDs as a safe and reliable contraceptive will also increase.*

**Table 3: CBFPT for Female Health Workers**

| District | Total to be Trained | Programmes Conducted | Total Trained | Percentage Trained | Remaining to be Trained |
|---|---|---|---|---|---|
| Aligarh | 368 | 26 | 104 | 28.2 | 264 |
| Allahabad | 640 | 45 | 181 | 28.3 | 459 |
| Meerut | 341 | 30 | 120 | 35.2 | 221 |
| Rampur | 235 | 22 | 88 | 37.4 | 147 |
| Sultanpur | 518 | 27 | 109 | 21.1 | 409 |
| Varanasi | 441 | 47 | 190 | 43.1 | 251 |
| **Total** | **2,543** | **198** | **792** | **31.1** | **1,751** |

Figure 1 – Percentage of Trained Female Health Workers Performing to Standard (as of March 1999)




By the end of February 1999, 680 female health workers had been trained in all six districts. By March, RFWTC observers had monitored 297 workers and found that 60 percent are performing to standards, indicating a significant improvement in the quality of IUCD insertion and removal services. SIFSPA is contemplating further steps to strengthen the training systems and increase the percentage of female health workers maintaining quality standards to at least 80. With these training programmes and follow-up measures, client satisfaction levels will increase, and, as a result, the acceptance of IUCDs as a safe and reliable contraceptive will also increase.

## Infection Prevention Training

One of the essential elements of good quality reproductive health services is the prevention of transmission of infections. Health care facilities are high-risk settings for transmission of infectious diseases because services are provided to many clients in a limited physical space. Providers as well as clients are susceptible to infectious diseases. Recognizing that reducing the risk of infectious diseases is an important component of high quality reproductive health services, SIFPSA implemented an infection prevention training programme. The primary objective of infection prevention

training is to protect service providers, other clinic staff, and the community from infectious diseases, that originate in health care facilities.

Infection prevention training is a two-day, on-site programme for all staff members working at a health care facility. SIFPSA identified medical officers, staff nurses, and public health nurses from each district to participate in a five-day TOT programme conducted by AVSC International. The trainers (six to eight per district) were divided into two teams to conduct on-site training programmes at all CHCs, PHCs, postpartum centres (PPCs), maternal and child health (MCH) centres, and women's hospitals. The programme emphasizes hands-on learning to enhance the service providers' infection prevention skills for MCH and family planning services.

The curriculum includes sessions on hand washing, glove use, surgical attire, antiseptics and disinfectants, decontamination, and processing, cleaning, and sterilization of instruments. Other topics covered include high-level disinfection, aseptic techniques, use and disposal of sharp instruments and multi-dose vials, and disposal of infected hospital waste. Trainees practice preparing 0.5 per cent chlorine solution, cleaning instruments, packaging linen, gloves, and instruments, and autoclaving. They are evaluated based on their demonstrated skills.

Participants considered the infection prevention training programme extremely useful. One medical officer said, "we have learnt about all these procedures and practices during our college days, but slowly and gradually forgot to use them. It was highly satisfying that these programmes reminded us of the dangers involved in not following infection prevention practices. If you had visited the clinics before and after training, you would have noticed the change, including the smell, at these places."

The teams have conducted training at all sites in Meerut, Varanasi, and Aligarh districts, and all sites in other districts will be covered by June 1999.

## Mini-Lap Training

Mini-laparotomy under local anesthesia is a safe and effective method of voluntary female sterilization. Compared to laparoscopic tubal ligation, it is much easier to perform, and it can be conducted in the postpartum period, post-abortion period, or any time when a woman is not pregnant. Mini-laps require simple equipment and instruments and are inexpensive and easy to maintain. Doctors with little surgical training can learn to perform the procedure in a short time, and the procedure can be performed on an outpatient basis. Mini-lap is particularly suited for places where support staff, equipment, and supplies are limited and the number of procedures conducted is low.

*Recognizing that reducing the risk of infectious diseases is an important component of high quality reproductive health services, SIFPSA implemented an infection prevention training programme. The primary objective of this training is to protect service providers, other clinic staff, and the community from infectious diseases that originate in health care facilities.*

CHC and PHC medical officers in DAP districts received mini-lap training. With the help of faculty from medical colleges, AVSC International and SIFPSA designed the six-day, interactive programme to teach a standardized procedure for performing mini-lap under local anesthesia. The training curriculum includes the following components: fundamentals of mini-lap under local anaesthesia, demonstration of the ZOE model, demonstration of mini-lap on the ZOE model and on a client, use of local anaesthesia, infection prevention, postoperative care and follow up, intra- and postoperative complications and their management, pain management, and quality assurance. Participants practice the procedure on the ZOE model before working with clients. The clinical trainers evaluate the performance of each participant for each procedure using checklists, ensuring that every participant is able to perform every skill competently.

Of the estimated 354 doctors in the DAP districts, 55 have received training. The rest will be trained in the next 2 years.

## Upgradation of Facilities

Also to improve the quality of reproductive health services at all PHCs, CHCs, and PPCs in DAP districts, SIFPSA undertook a systematic effort to upgrade facilities. AVSC International worked with district public sector staff to conduct an assessment of each CHC/PHC/PPC to identify the specific needs at each site, including repair and renovation of buildings, water supply, electricity (including generator sets), operation facilities, counselling rooms, equipment, and supplies. In collaboration with the Director General of Health Services, Uttar Pradesh, SIFPSA precisely defined the standards and constraints, providing guidelines for all assessments and estimates. The Civil Engineer of the Heath Department also visited the sites to prepare cost estimates. After SIFPSA obtained the technical sanction from the Director General of Health Services, it gave DIFPSA the authority to undertake the upgradation work.

DIFPSA followed the standard government procedures to select the contractors for the upgradation work. The CMOs followed government of Uttar Pradesh procedures to procure the equipment and other supplies. The upgradation work is complete at 29 sites and in

# Moving Beyond Barriers

## The Efforts of a Muslim TBA

A confident woman of 35 years, Fatima Bi sits erect without covering her face with the black veil as she speaks to outsiders. She has motivated 11 women for sterilization; 9 of them were Muslim. Given the traditional reluctance of population in Suar to adopt methods of family planning, let alone permanent methods, Fatima Bi's performance is commendable. As the CMO of Rampur pointed out, even though eleven is a small number, there were virtually no sterilizations performed in Suar before the TBA training programme.

The female health worker informed Fatima Bi about the dai training, and, keen to acquire new skills, Fatima Bi requested that female health worker to recommend her name. She attended training in November 1998 in a PHC along with 9 other *dais* from her area. She said that the training has helped her learn to deliver babies in much safer way. She recalls all procedures that were taught and recognizes the signs of a high-risk pregnancy. She now refers women with pregnancy complications to the PHC and, at times, even accompanies them. She also monitors other *dais* in her villages to ensure that they are following the practices taught in the training programme. Many *dais* speak highly of Fatima Bi and her efforts.

The *Maulevi* initially criticized Fatima Bi for motivating women for sterilization, but her husband and a few other friends supported her, convincing the *Maulevi* about her *Nek* (good) intentions. Whether or not the *Maulevi* was convinced of the benefits of the procedure, he ceased to interfere with her work.

progress at 50 sites. All work will be completed by July 1999, ahead of estimated time of completion.

DMs, CMOs, and the PMU in all districts closely monitored the upgradation work. In addition, the medical officers of selected sites were closely involved in the process at every stage. Because of the transparency in transactions, the work was of high quality and completed in a minimum amount of time. In some places, contractors even carried out additional work without additional cost.

**Upgradation of Subcentres**

INTRAH-PRIME, POLICY, and the PMU in each DAP district conducted the assessments of subcentre facilities using a standard checklist prepared in consultation with SIFPSA and the Director General of Family Welfare. The teams then prepared a complete census of all subcentres and the information collected was entered into a computer database. In the first phase, subcentres located in government buildings were upgraded.

For subcentres not located in government building, SIFPSA increased the budget for rent of subcentre buildings from Rs 50 per month to Rs 350 to encourage female health workers to rent a two-room accommodation. Two-room accommodations are also eligible for upgradation. CMOs have initiated the process of finding suitable accommodation in all districts, and 58 buildings were rented in the first year. This will considerably improve the quality of services and provide much needed privacy to clients.

## Dai Training

In the Rampur district, the DAP calls for a *dai* training programme to train at least one *dai* from every village. To help identify *dais*, female health workers prepared subcentre maps with village boundaries and plotted *dais* working in the area. From the list prepared by the female health workers, the district selected those who conducted at least six deliveries a year for training, identifying 1,200 *dais*. The *dai* training programme is a collaborative effort of the public and private sectors; a PVO working in Rampur conducts the training programmes with the help of staff from health department. By the end of March 1999, they had trained 891 *dais*.

Medical officers, supervisors, block health and education officers, and representatives of

PVOs served as master trainers. The one-week TOT programme was conducted in May and November 1998 in Lucknow. These master trainers, together with the CMO of Rampur, selected 42 female health workers and supervisors to serve as lead trainers.

Two master trainers and two lead trainers conducted each six-day programme for 10 *dais* from one or two subcentre areas. In addition, the female health workers of the area attended as observers to familiarize themselves with the training contents and the *dais* selected from the subcentre area. After the training, *dais* received photo identity cards signed by the CMO and a *dai* kit including a mucus extractor, a baby weighing scale, a plastic sheet, 10 hand gloves, a kidney tray, a bowl for the placenta, scissors, a tin plate, and a book for record keeping. One-day refresher training programmes were conducted six months after the initial training.

According to the 1995 PERFORM survey, only 10 per cent of total deliveries in the Rampur district were attended by trained health personnel, and the proportion of those deliveries attended by trained *dais* was insignificant. In May 1999, POLICY conducted a household survey to determine the proportion of deliveries attended by trained personnel, four months prior to the survey. The survey results showed that 24 percent of deliveries were attended by trained personnel, and nearly 55 percent of these deliveries were assisted by trained *dais*. In less than a year, the *dais* training programme increased the rate of deliveries attended by trained personnel from 10 to 24 percent. This increase will have a significant impact on maternal and infant mortality and morbidity in the district.

**Impact of Dai Training**

INTRAH-PRIME conducted an independent qualitative survey and found that, as a result of training, *dais* understand their expanded role. They learned to register pregnant women with ANMs, provide antenatal, natal, and postnatal care and services, refer cases that involve complications and risk, provide family planning counselling and supplies, and keep records of deliveries conducted.

*A survey conducted on the impact of dai training shows that, as a result of the training, dais understand their expanded role. The training improved the status of dais in the community, thereby increasing demand for their services.*

The training improved the status of *dais* in the community. Recognition as a trained *dai* increases demand for their services. In addition, their status is affirmed by the identity card and name plate.

Trained *dais* now provide female health workers with information about women in need of antenatal, natal, and postnatal services and act as a link between public health personnel and the community. This communication is crucial to making motherhood safer. In addition, of all the new practices and methods advocated during the training, *dais* have

# Mobilizing Additional Resources

## The Role of an ISMP

Tarun Ghosh was born and brought up in Kishan Ganj, West Bengal state. After completing the high school studies, he attended a local medical training institution and received a certificate. However, there were already many medical practitioners in the area, and Tarun contacted his uncle, a medical representative in Allahabad, for help.

Following his uncle's advice, Tarun established a small private practice in a village, 60 kilometers away from Allahabad town. At first, not many clients visited him for services. Realizing that a nameplate with qualifications was not sufficient to develop rapport with the community, Tarun regularly visited four nearby villages. The number of clients seeking his services gradually increased, and he is now a busy practitioner.

The Allahabad Agriculture Institute is responsible for implementing the SIFPSA-funded ISMP training project in the district. The Institute identifies ISM practitioners with good client load in the villages. Tarun, given his flourishing private practice, qualified for the training. The project staff informed him about the training and persuaded him to attend. During the training programme, Tarun met the female health worker covering the villages in his area and learned about the services available at the PHC.

After the training programme, Tarun advised several of his clients to accept modern family planning methods. He refers sterilization and IUCD clients to the female health worker, who in turn supplies him sufficient quantities of condoms, oral pills, and IFA tablets. He currently provides services to more than 35 regular users of condoms and oral pills. He also recruited five sterilization clients last year. In recognition of his skills and performance, the ISMP training project awarded him a wall clock, which he proudly displays in his clinic.

been most successful in convincing their clients to feed the first milk to their child. Most have also discontinued the traditional practice of discarding colostrum.

Dais have become an important resource for the government health machinery. Female health workers involve them in various activities, including the recruitment of family planning acceptors. Dais are also referring complicated cases to the health workers, ensuring adequate and immediate medical attention and reducing the risk to the health of the mother and child.

## Indigenous System of Medicine Practitioners

Uttar Pradesh has nearly 43,000 registered Unani, Ayurvedic, and Homeopathic medical practitioners and, likely, an equal number of unregistered practitioners. Many people in villages and urban slums, who have limited access to public health facilities and cannot afford to pay fees to private practitioners depend on indigenous practitioners for services. A study conducted by the OPTIONS project found that 43 percent of ISMPs provided family planning services, and nearly all of them are willing to provide family planning services. Realizing that these providers are a large and latent source that has the potential to improve access to family planning services, particularly condoms and oral pills, SIFPSA initiated a pilot ISMP training project in Jhansi and Sitapur (two non-DAP districts of Uttar Pradesh).

The POLICY Project conducted an evaluation of the pilot projects and the findings were encouraging; many practitioners reported an increase in family planning clients, as well as in their overall client load. The intervention not only increased overall access to family planning services, but also improved the indigenous practitioners' social status.

Taking the experiences of the pilot projects into consideration, the district planning teams included ISMP training activities in the DAPs for Aligarh, Allahabad, and Varanasi. Nearly three-quarters of the targeted ISMPs in these districts have been trained, and the remaining quarter will be trained in the next six months (Table 4).

The ISMP project in these districts has been in place for two years. Both registered and unregistered

*Many practitioners reported an increase in family planning clients, as well as in their overall client load. The intervention not only increased overall access to family planning services, but also improved the indigenous practitioners' social status.*

**Table 4: Status of ISMP Training as of March 31, 1999**

| | *Planned Performance* | *Actual Performance* | |
|---|---|---|---|
| **Institution** | **To be Trained** | **Trained** | **Percentage Trained** |
| Ajmal Khan Tibbiya College, AMU, Aligarh | 750 | 421 | 56.1 |
| Allahabad Agriculture Institute, Allahabad | 900 | 603 | 67.0 |
| PSM Department, Varanasi Medical College, Varanasi | 2100 | 1800 | 85.7 |
| **Total** | **3750** | **2824** | **75.3** |

practitioners are eligible for training, but SIFPSA decided to target registered practitioners in the first phase of the project. The training lasts four days and covers various topics related to population growth, including reasons for high fertility, effects of high fertility on the health of mothers and children, reproductive biology, interpersonal communication, family planning counselling, gender equality, male responsibility, empowerment of women in decision making, information on oral pills and condoms, screening procedures, record keeping, making referrals, and STD/HIV/AIDS. The trainees take pre- and post-evaluation tests, and those who do not pass the first time are given another chance. In addition, on the last day of training, block-level health functionaries provide oral pills and condoms to the ISMPs. The training agency staff frequently follow up with the trained ISMPs to review records and provide reorientation training. During these monitoring visits, the trainers also meet with public health system staff to discuss the ISMPs in the area, helping to establish rapport and referral links between ISMPs and the public health system.

# Improving Access to Integrated Services

## Reproductive and Child Health Camps

To provide integrated reproductive health services, SIPFSA developed the RCH camp approach. In these camps, a team of doctors visits one facility (either a block PHC or a CHC) on the same day to provide RCH services, increasing access and improving the quality of the services available to women and children. This integrated approach to providing maternal and child health and family planning services is more cost-effective and more convenient for clients. In February 1998, SIFPSA decided to experiment with RCH camps in all the PERFORM districts, and for fiscal year 1998-99, included plans for RCH camps in the DAPs.

To implement the RCH camp approach, planners had to consider several questions.

**Questions for DAP Planners**

What type of RCH services should be provided?
Who should provide them?
What equipment and instruments are needed?
How should the RCH camps and their services be publicized?
What logistical support will be needed?
How often should the camps be conducted?
Who should monitor the quality of the camps?
What will be the budgetary requirements?

Planners agreed that the camps would include a gynecological checkup, child checkup and immunization, family planning and counselling services, and transportation for sterilization clients. To continue the planning process, SIFPSA classified the needs in the following five categories:

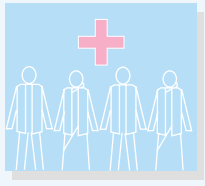
(1) publicity
(2) manpower
(3) camp arrangements
(4) equipment
(5) transport and post-camp provisions

SIFPSA decided to hold one camp per month at each service site from May to September, and two per month from October to March. They budgeted and approved Rs. 1750 per camp for publicity, food, transport, tent and chair hiring charges.

During the planning process, it became clear that transportation would be a major barrier to the implementation of the camps. To solve this problem, all vehicles in need of repair were fixed. In addition, SIFPSA purchased six new vehicles each for Allahabad, Sultanpur, and Meerut and three vehicles each for Varanasi and Aligarh. They also increased the budget for petrol and maintenance in the DAP districts. These efforts provided the districts with a sufficient number of vehicles to transport doctors to the RCH camp sites and to provide transportation for sterilization clients.

SIFPSA conducted orientations for the public health system and the PMU of the respective districts about the RCH camps. At the orientations, SIFPSA and the district teams discussed the schedules, publicity requirements and other support services for the camps. They also nominated the surgical team and designed forms for monitoring and evaluation of the RCH camps. The monitoring forms included sections on readiness, supplies, expenditure (cumulative), services, and performance. SIFPSA asked the district teams, including the PMU and representatives of the public health system, to coordinate, attend, monitor, and submit a report about the RCH camps.

# RCH Camp Planning Checklist

✓ 

## Manpower

Surgeons, gynaecologist, anaesthetist, lady doctor

✓ 

## Publicity

Newspaper announcements, banners, audio cassettes, public address systems, pamphlets, posters

✓ 

## Camp Arrangements

Layout of services (mobility for operating teams), waiting areas, tents, chairs, food refreshments, lines mattresses, pillows generators

✓ 

## Transport and Post-camp Provision

Transportation for doctors, district officers, and sterilization acceptors (vehicle maintenance and POL ); follow-up medicines; counselling/IEC materials

✓ 

## Medical Equipment

Bleach, utility and surgical gloves, lab reagents, suture material, antiseptics, dressing material, medicines for sterilization, anaemia medicine, washing arrangements, laparoscopes (two per sterilization team), laparoscopic support instruments

**Table 5: Services Availed by Clients at RCH Camps in Aligarh, 1998-99**

| Month | Camps held | Ob-gyn Checkup | ANC | Immunizations | | Counselling | Sterilization | Spacing Methods |
|---|---|---|---|---|---|---|---|---|
| | | | | Mother | Child | | | |
| June 98 | 11 | 117 | 66 | 62 | 49 | 182 | 8 | 126 |
| July 98 | 11 | 220 | 174 | 56 | 72 | 878 | 7 | 696 |
| Aug 98 | 11 | 240 | 154 | 97 | 162 | 876 | 3 | 565 |
| Sept 98 | 11 | 205 | 154 | 70 | 114 | 867 | 20 | 263 |
| Oct 98 | 11 | 187 | 166 | 79 | 274 | 566 | 48 | 240 |
| Nov 98 | 22 | 408 | 181 | 71 | 85 | 1296 | 161 | 554 |
| Dec 98 | 22 | 454 | 223 | 21 | 60 | 1498 | 223 | 276 |
| Jan 99 | 22 | 357 | 212 | 63 | 31 | 1136 | 188 | 365 |
| Feb 99 | 22 | 377 | 220 | 84 | 87 | 1206 | 188 | 507 |
| Mar 99 | 22 | 353 | 246 | 102 | 121 | 2065 | 145 | 757 |
| **Total** | **166** | **2918** | **1796** | **705** | **1055** | **10570** | **991** | **4349** |

After these orientations, SIFPSA delegated the responsibility for organizing the camps to the districts.

The planning process for each camp was complex and required the collaboration of the PMU, district officers, and public sector health staff. Following SIFPSA guidelines, district teams made arrangements for all of the items shown on the checklist below.

Overall, 1,128 RCH camps were conducted in the DAP districts. On average, each district publicized the camps through 4 newspaper announcements, 16 banners, IEC posters, pamphlets/ handbills, and an audiocassette that was played in a hired vehicle that drove around the villages. The organization of the camps was successfully decentralized to the PHC/CHC level, and all the required equipment and supplies were dispatched from the district to the camp sites well in advance.

The camps were especially important in providing integrated reproductive health services. The records from Aligarh district demonstrate the demand exhibited by clients for various services (Table 5).

The camps began in May 1998, and continued through March 1999. SIFPSA originally proposed 1,409 camps; 1,128 (80 percent) were successfully organized. On average, 50 clients attended each RCH camp. More than half the clients attended the camps for the integrated MCH services. The integrated approach was very successful in making these

**Table 6: Contribution of RCH Camps to Sterilization Performance, 1998-99**

| District | Total Camps | Average Sterilizations per RCH | Total Sterilizations Conducted in RCH Camps | District Sterilizations Performance | Percentage of Sterilizations Conducted in RCH Camps |
|---|---|---|---|---|---|
| Aligarh | 166 | 6.0 | 991 | 4609 | 21.5 |
| Allahabad | 334 | 15.6 | 5329 | 11487 | 46.4 |
| Meerut | 171 | 7.2 | 1332 | 7733 | 15.8 |
| Rampur | 105 | 7.0 | 732 | 2757 | 26.6 |
| Sultanpur | 231 | 13.4 | 3098 | 7297 | 42.6 |
| Varanasi | 121 | 33.7 | 4074 | 12562 | 32.4 |
| **Total** | **1128** | **13.8** | **15556** | **46445** | **33.4** |

services accessible to clients. At the same time, the contribution of the camps to family planning performance in the districts was also significant, especially for sterilizations. More than 15,000 sterilizations were conducted in the camps, approximately one-third of overall performance for the six districts. The average number of sterilizations per camp was 14, ranging from 6 in Aligarh to 34 in Varanasi (Table 6).

The RCH camps were a success, not only in providing services, but

also in raising community awareness and mobilizing institutional support of reproductive health. The DMs and the DIFPSA committees played an important role in facilitating the implementation and monitoring the RCH component of the programme. Other government officials (including CDOs, BDOs, *lekhpals*, and *pradhans*), religious and local elites, and NGO representatives also provided support and contributed to the success of the intervention. Many doctors reported that people have come to them and suggested that the routine sterilization camps conducted as part of the central government programme should be organized as RCH camps. The PMUs and district officers agree. The camps provide an opportunity to integrate the efforts of providers and increase access to reproductive health services.

# Involving the Non Governmental Sector

In addition to the public sector initiatives in the district action plans, SIFPSA sanctioned two sets of nongovernmental sector projects: (1) PVO and organized sector projects covering villages and urban slums; and (2) cooperatives. With the help of development and district officers in the DAP districts, SIFPSA staff compiled a list of private voluntary agencies and major industries and visited each organization to assess its capabilities. They developed a short list based on the organization's date of registration, physical presence and infrastructure, previous experience, and reputation. SIFPSA asked these organizations to submit the proposals. SIFPSA reviewed the proposals and provided comments, and the organizations submitted revised proposals to SIFPSA's Project Advisory Committee for technical approval. All PVO and organized sector projects are initially for a period of 3 years, and extension of the project period depends on the performance in the first three years. The performance of each project is measured against specific family planning acceptor and immunization objectives. An external agency will conduct the performance evaluations.

## Innovative PVO and Organized Sector Projects

SIFPSA sanctioned 28 innovative PVO and organized sector projects, covering 3.7 million people in 1,769 rural villages and urban slums. At the village level, CBD workers are the central feature of PVO and organized sector projects. There are 1,587 CBD workers working in PVO and organized sector projects in the DAP districts.

Recruitment procedures for CBD workers vary from project to project. In general, the woman should be educated through the eighth standard, living in the same village, married, and,

preferably, a current user of a modern contraceptive method. The organizations also consult *pradhans* and local influentials in the selection process.

Project coordinators and supervisors attend a training session conducted by PRERANA and sponsored by SIFPSA and CEDPA. The training covers a variety of topics including social mobilization, counselling skills, reproductive health services, quality of care, IEC, information systems, financial systems, monitoring procedures, marketing of contraceptives, and sustainability issues. In turn, project coordinators and supervisors train their CBD workers.

All the projects conducted baseline surveys, and CBD workers record services provided in diaries. Project managers hold monthly meetings for CBD workers to review performance and address problems. PVOs submit quarterly performance reports and expenditure statements to the PMU and SIFPSA. SIFPSA nodal officers visit each project once a month and, with the help of PMU staff, conduct client verification by randomly selecting the clients from the current users list provided by the PVO. SIFPSA computerized all information related to the PVO projects and streamlined procedures for release of quarterly funds within 15 days of submission of the previous quarter expenditure report.

In addition, the PMUs conduct monthly meetings for all PVO project coordinators to share successful experiences and

**Table 7: Family Planning Performance of PVO and PCDF Projects**

| District | Projects | Pop. (000s) | Villages | CBD Workers | Current Users (as of March 1999) IUCD | Orals | Condoms | Total |
|---|---|---|---|---|---|---|---|---|
| **PVO and Organized Sector Projects** | | | | | | | | |
| Aligarh | 3 | 374 | 310 | 135 | 321 | 1,480 | 882 | 2,683 |
| Allahabad | 4 | 527 | 451 | 248 | 162 | 1,563 | 2,546 | 4,271 |
| Meerut | 7 | 666 | 247 | 165 | 2,741 | 7,393 | 11,090 | 21,224 |
| Rampur | 2 | 256 | 155 | 52 | 1,885 | 1,498 | 3,471 | 6,854 |
| Sultanpur | 7 | 1,174 | 98 | 701 | 247 | 5,862 | 6,935 | 13,044 |
| Varanasi | 5 | 714 | 508 | 286 | 701 | 4,485 | 7,547 | 12,733 |
| Total | 28 | 3,711 | 1,769 | 1,587 | 6,057 | 22,281 | 32,471 | 60,809 |
| **PCDF Projects** | | | | | | | | |
| Aligarh | 1 | 1,450 | 550 | 342 | 2 | 685 | 1,002 | 1,689 |
| Meerut | 1 | 1,850 | 500 | 530 | 255 | 11,664 | 17,246 | 29,165 |
| Sultanpur | 1 | 920 | 271 | 170 | 1 | 2,865 | 1,586 | 4,452 |
| **Total** | **3** | **4,220** | **1,321** | **1,042** | **258** | **15,214** | **19,834** | **35,306** |

# Distribution of Contraceptive to PVO Projects

All PVO projects are dependent on the public sector for supply of contraceptives. One of the major problems has been the unreliable supply of contraceptives. As the number of clients recruited by PVO projects has increased, so have the contraceptive requirements. In Aligarh, PVO representatives sent several requests to the CMO and raised the issue in the monthly meetings of PHC medical officers at the district level, but to no avail.

The PVOs raised the issue in a monthly meeting with the PMU. After several rounds of discussion, they decided to request the Aligarh CMO to separate distribution of contraceptives to the public and private sectors and allow the PMU to directly handle contraceptive distribution to PVOs. At first, the CMO was reluctant because he thought that government health institutions would suffer shortages and he was concerned about accountability. A SIFPSA representative assisted PMU and PVO staff in convincing the CMO by pointing out that PVO performance would improve the district's overall performance. The CMO finally agreed to entrust the responsibility of contraceptive distribution to the PMU.

The PMU receives reports from PVO project coordinators every month and calculates contraceptive requirements. The supplies are obtained from the district store. At the monthly meetings of PVOs, the PMU distributes the contraceptives as required. Since these arrangements were put in place, not a single PVO has reported a problem with contraceptive supply.

address problems. The CMO or Deputy CMO of the district attends these meetings to address coordination issues with government health institutions. The meetings also provide an opportunity for district officers to request the help of PVOs, particularly for RCH camps. The PMU is a vital link between government health personnel and PVO staff.

During 1998-99, PVOs provided services to 6,057 IUCD users, 22,281 oral pill users and 32,471 condom users (Table 7). Most PVOs achieved their first-year objectives, and their contribution to the overall increase in contraceptive prevalence in DAP districts has been significant.

## Cooperative Sector Projects

In Meerut, Sultanpur, and Aligarh districts, SIFPSA also sanctioned three large-scale projects under the auspices of the Pradeshik Cooperative Dairy Federation (PCDF). The cooperative projects actually cover more population than all 28 PVO projects combined. The PCDF projects in Aligarh and Sultanpur are still in the process of recruiting and training CBD workers, yet they already served 35,306 spacing method users last year . The contribution of the cooperatives is likely to be significant when the projects become fully functional next year. The PCDF projects have more or less similar staffing pattern, training schedules, and reporting systems as the PVO projects. In addition, the PCDFs enjoy the advantage of support from village dairy cooperatives and their executive committee members. They also understand marketing and quality assurance principles from their work with milk distribution and have initiated social marketing as part of these projects.

# The Rohit Initiative

Rohit Serva Bal Vihar Hitkari Siksha Prachar Sabha (Rohit) is a private voluntary organization registered in Meerut. Rohit runs two schools for poor children in Meerut, and, in the past, implemented a series of education, vocational training, and child development projects concerned with education. In 1997, SIFPSA granted a project to Rohit to increase the prevalence of modern contraceptive use, particularly spacing methods, in 20 urban slums of Meerut covering a population of 115,080.

At the time of the baseline survey, there were a total of 1,648 oral pill and condom users in the project area. After a two-year effort by 30 CBD workers, users of pills and condoms increased to 4,119. However, Rohit was dependent on the free products supplied by the Office of the Chief Medical Officer of the district. That supply system was erratic, unreliable, and did not offer any choice. In addition, the perceived quality of the products was low.

At about the same time, SIFPSA began to encourage PVOs to initiate steps to sustain activities after the project period. With the help of the SOMARC project, they launched training programmes on social marketing of contraceptives. Rohit was one of the first organizations to positively respond to this effort. On July 7, 1998 SOMARC provided training to Rohit staff.

At first, Rohit was unsure about the brands of condoms and oral pills it should sell and how it would meet the financial costs involved in launching the social marketing of contraceptives. After considerable deliberation, the Project Director wrote to SIFPSA requesting specific funds for social marketing. In January 1999, SIFPSA provided Rs 10,000 as revolving fund for contraceptive social marketing activities. Rohit now offers 10 brands of contraceptives and 4 brands of oral pills in different price ranges procured from two contraceptive marketing agencies.

In the first three month period, Rohit sold 470 packets of condoms and 306 cycles of oral pills to clients who otherwise were using free products. According to the Project Coordinator, “this is just a beginning, but we realize the potential is immense. The users want better quality products and are willing to pay.” Based on the initial success, Rohit plans to phase-out the supply of free products and ultimately depend on subsidized and commercial products. They also plan to market select consumable products gradually to augment the income of CBD workers and pave the way for sustaining activities after the project period.

The Rohit initiative has had a chain reaction. Many SIFPSA-funded PVOs working in Meerut would like to emulate the strategy. Recognizing the potential of this approach, the PMU of Meerut organized a one-day meeting for Rohit to share its social marketing experience with other PVOs. As a result, three additional PVOs launched contraceptive social marketing initiatives in their project areas with the help of SIFPSA’s revolving fund.

# Monitoring Performance

An important component of DAP implementation is performance monitoring. SIFPSA developed a new software package for computerizing the information and trained PMU staff. PMU staff then developed financial, administrative, and information systems for their district. The evaluation forms for the training interventions and follow up were designed specifically for these systems, and all records are maintained at the district level. The PMUs share the reports with SIFPSA.

These systems are also used to monitor district performance for DAP objectives and IFPS benchmarks.

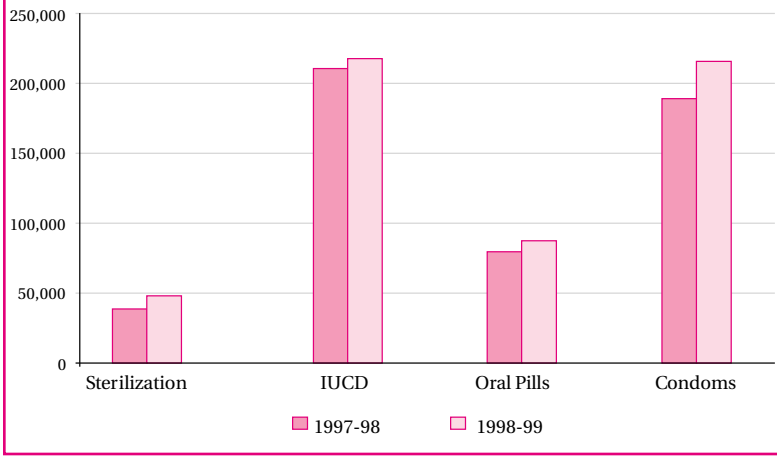
**Family Planning Performance**

Family planning performance has also improved during the first year of DAP implementation. The overall performance of the districts increased for all methods: sterilizations from 38,002 to 46,445; IUCDs from 210,589 to 217,488; oral pills from 78,401 to 86,346; and condoms from 189,546 to 215,654 (Figure 2). Decentralized planning certainly has not hindered performance in the family welfare sector. The participatory planning process and decentralized implementation have resulted in the anticipated benefits. Providing integrated services, improving the quality of those services, and increasing access to services have all contributed to the gains in performance in the DAP districts.

**Family Planning Performance by District**

In most of the DAP districts, the increase in sterilization performance was substantial. This is primarily attributable to the contribution of the RCH camps. As discussed earlier, these camps accounted for nearly one-third of overall sterilization performance. The increase in IUCD performance is based on the performance in Allahabad,

Figure 2 – Family Planning Performance in DAP Districts




Rampur, and Sultanpur. Oral pill performance increased in five DAP districts. The increase was particularly noticeable in Allahabad and Sultanpur. Condom performance also improved in five districts, and the improvement was significant in Aligarh, Allahabad, Sultanpur, and Varanasi. One reason for this performance could be the role of the trained ISM practitioners in Aligarh, Allahabad, and Varanasi in making condoms more accessible. The performance by method for each district is presented below.

Although the performance for specific methods varied from district to district, overall, more women in the six districts had access to and accepted a family planning method. The lower performance in Meerut is partially due to the lack of continuity in district leadership during the first year of DAP implementation. A significant achievement of DAP implementation is that strides have been made in improving access to and quality of a broad range of services without hindering family planning performance. In fact, five of the six districts exceeded the IFPS benchmarks; the sixth, Aligarh, is likely to achieve its benchmark level by July 1999. In addition, the quality of the family planning services provided to women in the districts was improved.

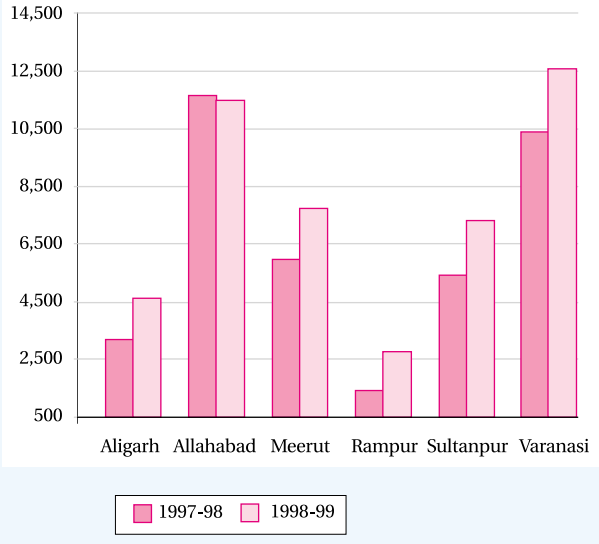
**Iron Folic Acid (IFA) and Tetanus**

The DAPs also include objectives for IFA tablets and TT vaccinations. In 1998, the government of India did not

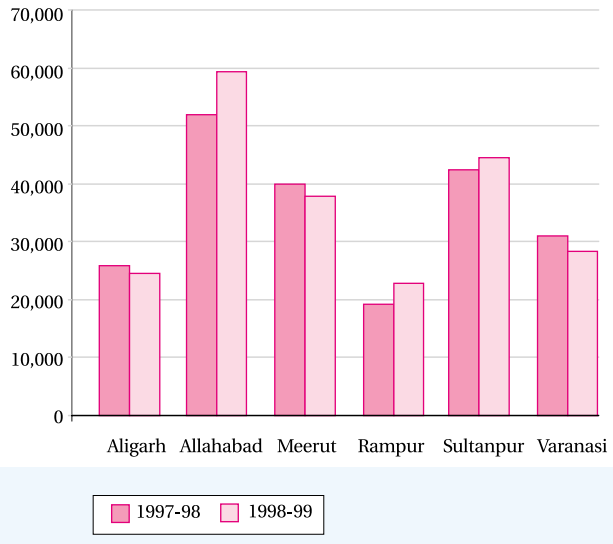
*Providing integrated services, improving the quality of those services, and increasing access to services have all contributed to the gains in performance in the DAP districts.*

# Method-wise District Performance
# 1997-98 and 1998-99

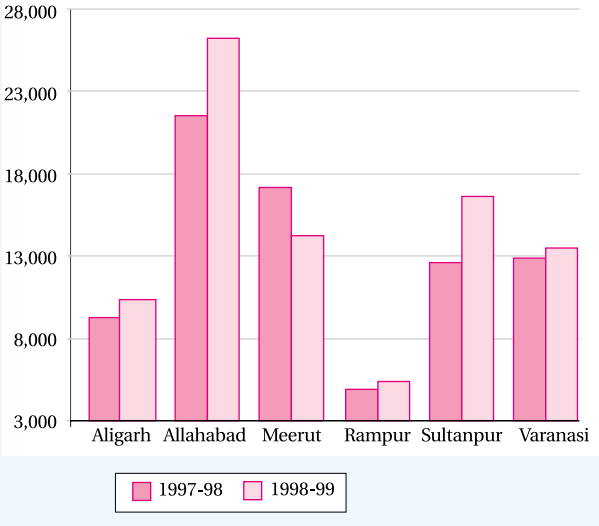
## Sterilization performance in DAP Districts
## 1997-98 and 1998-99




## IUCD Performance in DAP Districts
## 1997-98 and 1998-99




## Oral Pill Performance in DAP Districts
## 1997-98 and 1998-99




## Condom Performance in DAP Districts
## 1997-98 and 1998-99

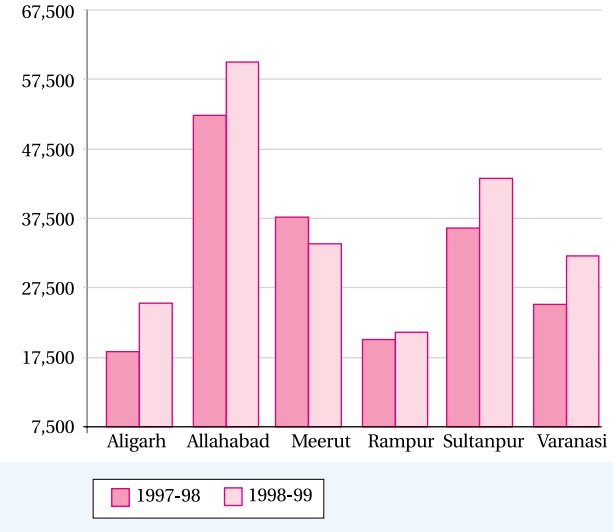
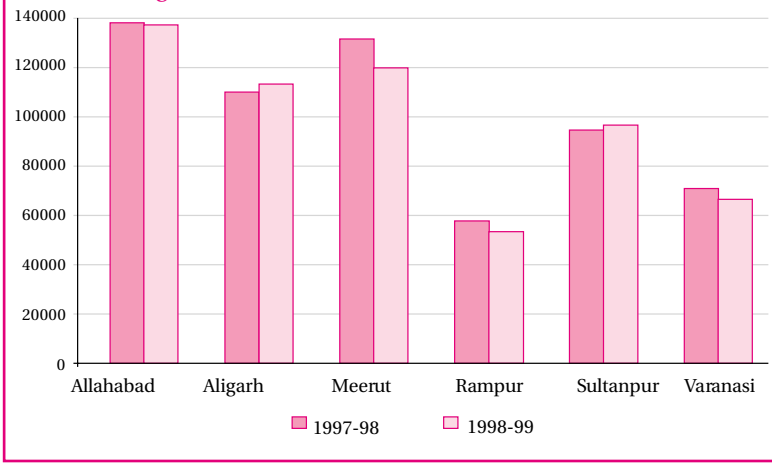


Figure 4 – TT Performance, 1997-98 and 1998-99




procure IFA tablets. Thus, the performance of the DAP districts is entirely based on the stock available and cannot be compared to the 1997-1998 performance because of problems at the central level. The decentralized distribution systems operated as expected, and performance will likely increase next year when the additional procurements are available.

For TT vaccinations, overall performance matched 1997-98 performance and exceeded the 1998-99 benchmarks. The performance of the districts is shown in Figure 4.

# Budgeting

## Budget Allocations to DAP Districts

A major innovation of the DAPs is the introduction of the performance based disbursement system (PBDS). The PBDS involves performance benchmarks and verifiable indicators. Based on the annual objectives set for the DAP districts, SIFPSA and USAID negotiated and reached an agreement on benchmark indicators. In the first two-year period, indicators for the DAP districts include number of new clients of modern family planning methods recruited by public sector and private sector, number of pregnant women given IFA tablets and Vitamin A solution, number of upgraded health institutions, and number of trained health personnel performing to standard in a given year. The benchmarks for the final year performance concentrate on output indicators, such as increased contraceptive prevalence rate.

SIFPSA and USAID also estimated the financial resources required to achieve the performance indicated in each benchmark. Disbursement of money from USAID to the government of India, and subsequently to SIFPSA, is based on performance. If the districts achieve the expected level of performance, the money is released; if they do not meet the benchmarks, the funds are not disbursed. In the first year, five of the six DAP districts exceeded the expected levels of performance.

The total approved budget for all six districts is Rs 433 million. Before the launch of the DAPs, SIFPSA approved several PVO projects in these districts, but after the establishment of PMUs, these projects were integrated with the DAP budgets. Of the total budget for each district, 55 percent was for projects in the private sector, 37 percent for activities in the public sector, and the remaining 7.7 percent for

Figure 5 – Private Sector Allocations in DAP Districts

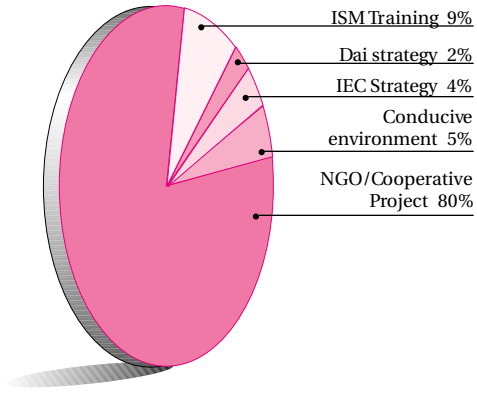
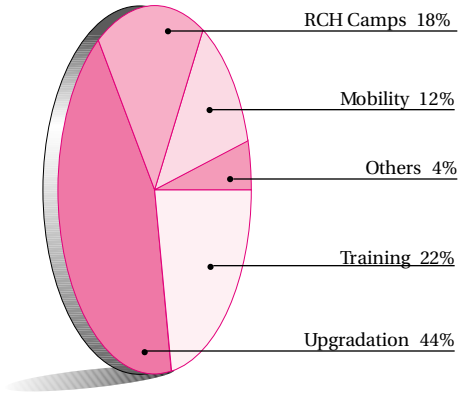



Figure 6 – Public Sector Allocations in DAP Districts




management expenses. Of the private sector budget in the DAP districts, 80 percent was allocated to PVO, cooperative, and organized sector projects that employ the CBD worker approach. The remaining 20 percent is earmarked for ISMP and dai training, IEC strategies, and meetings with religious leaders and *pradhans* (Figure 5).

The public sector budget of Rs 174 million also has specific line items. Of the total amount, 22.2 percent is earmarked for technical and other training; 44.4 percent for upgrading health facilities; 18.2 percent for RCH camps; 11.8 percent for transportation; and the remaining 3.5 percent for MIS, logistics, supplies, and the CMO office (Figure 6).

# Achievements

## Systems and Processes

- For the first time, decentralized RCH district action plans were prepared and the systems for decentralization were designed and implemented. The plans cover a population of 17.8 million in 8,307 villages and more than 50 towns.
- A participatory approach involving partners from private, industrial, NGO, cooperative and government sectors was used to set objectives and develop strategies.
- Procedures for project implementation were well defined and codified, leaving no ambiguity and facilitating decentralized decision making.
- Project Management Units were established, management information systems were designed, and software for computerized data analysis was developed.
- District-level societies were created, and financial and decision-making authority was delegated to the societies.
- Mechanisms were established to identify and solve problems efficiently. The PMUs at the district level gained recognition as problem solvers.
- Collaboration among partners was encouraged and strengthened, and an integrated approach was institutionalized.

## Creating a Conducive Environment

- 837 leaders from different religious groups attended the meetings and pledged their support to the RCH programme.
- Links between *pradhans* and the health department were established for the first time. Nearly two-thirds of *pradhans* were trained, and trained *pradhans* made a significant contribution to the programme.

## Generating Demand

- The interpersonal counselling skills of workers in both the private and public sectors were improved, and they used the campaign theme Aao Batien Karein to conduct IEC activities.
- Scripts conveying reproductive health messages were developed for folk performances, including Nautanki, Qawali, Puppetry, and Allah/Birha. Performances were conducted in all villages with more than 2,000 population in areas covered by PVO projects. The villagers' response to the folk performances was overwhelming.

## Improving Quality

- 792 female health workers received IUCD insertion and removal training and were provided IUCD kits. Sixty percent of the trained female health workers are now performing to quality standards.

- All health personnel working in CHCs, PHCs, PPCs, and hospitals received infection prevention training, resulting in improved infection prevention practices at service delivery points.

- Standards were set for upgrading facilities, and the procedures were simplified and decentralized. Twenty-nine CHCs and PHCs were upgraded, leading to considerable improvement in quality of services.

- In Rampur, 891 *dais* were trained and provided with a dai kit, an identity card, and pictorial registers. After the training programmes, the proportion of deliveries attended by trained personnel increased from 10 to 24 percent.

- 2,824 ISMPs were trained in three DAP districts, and the system for follow up of trained ISMPs was streamlined.

- 1,128 integrated RCH camps were conducted. The camps provided a wide range of maternal and child health and family planning services and represented a successful convergence of efforts and services.

## Innovative Projects

- 28 innovative PVO and organized sector projects were funded covering a population of 3.7 million in 1,769 villages. These projects served 60,809 users of spacing methods.

- Village diary cooperatives covering a population of 4.2 million were involved in delivery of RCH services in Meerut, Aligarh, and Sultanpur districts.

## Performance

- Benchmark indicators were identified, and a performance based disbursement system was negotiated and implemented.

- Performance for all methods of family planning in both the private and public sector improved considerably. In fact, five districts exceeded the expected levels of performance. For sterilizations alone, the performance of DAP districts increased by 22.9 percent from 1997-98 to 1998-99; the state average increase for the same period was only 12.9 percent.

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